Frequently Asked Questions – Road to Recovery Behavioral Health Reform

1. **What is the purpose of behavioral health reform?** Behavioral health reform focuses on serving persons with mental illness closer to their home communities, support systems, family and friends in the least restrictive environment that provides safety and protection for the individuals and the community.

2. **How will consumers be involved in the BH reform?** The Department of Health and Human Services (HHS) Behavioral Health System has long valued active consumer participation in the state administration of BH services in Nebraska. The HHS BH System has employed two full time staff persons for more than 10 years who are consumers of behavioral health services. They continue to impact, direct, and guide policy development and system change for the State of Nebraska.

   Behavioral health consumers are represented on the mental health and substance abuse advisory committees, both at the state and regional levels, and are also actively involved in BH Reform. Consumers interested in Behavioral Health Reform have been welcomed to participate at regional and statewide meetings held by the Governor, Senator Jensen, and the Director of HHS. They will continue to be invited to planning and informational meetings over the next few months.

3. **How does moving services to the community improve quality of care?** Consumers will be served most appropriately and closer to their home communities, current health care providers, support groups, family and friends. Providing acute inpatient or secure residential services closer to a person's home facilitates long term recovery, eliminates an "institutionalization" stigma that is less conducive to good treatment outcomes, provides better continuity of care with community providers, makes family visitation easier, and results in less disruption of care when discharged.

4. **What's being done to ensure that citizens don't fall through the cracks?** The Road to Recovery focuses on people who would've been served at a Regional Center -- persons committed by MH Commitment Boards for involuntary treatment. The same service capacity will be developed and operating as smaller acute inpatient and secure residential services before a Regional Center(s) is closed. Upon discharge, more support services will be available, closer to home, to help reduce recidivism and help keep people from "falling through the cracks."

5. **What services will become available in the community?** There is a long list, ranging from acute inpatient, secure residential and medication management services developed to replace Regional Center capacity, to additional or expanded rehabilitation and support services to persons in independent and assisted living situations. Other examples include transportation, day rehabilitation, tele-health, and geriatric psychiatric services.

6. **How will the transition to community services be funded?** A total of approximately $50 million dollars will be directed toward creating acute inpatient, secure residential and support services in communities:

   $29.0 M Redirected from Regional Center inpatient care to community care and new or expanded acute inpatient and secure residential services (current inpatient svcs funding)
   6.0 M One-time infusion to create new programs (Health Care Trust Funds)
   9.0 M Federal Medicaid funding generated by transition to community services (60% federal / 40% state match)
   2.5 M For emergency protective custody (double current funding)
   3.5 M To develop affordable housing

7. **Are counties expected to contribute more to behavioral health?** None of the funding proposed for new or expanded services will come from counties. Counties will not pay the current Regional Center per diem for the proposed community-based services. In fact, the county portion of the inpatient cost at the Regional Centers should decrease as length of stay decreases, as a result of the development of increased community services. State funding will be moved to community providers, allowing access to previously unavailable federal funds (60% federal, 40% state).

8. **How will services be developed and operating in the community in only 18 months?** Certain services such as acute inpatient services are already operating in some community hospitals in Nebraska. With one-time development funds, expanding these services to include residential services will be attainable. The BH Regions have been directed to have their plans finalized by June, 2004. The 18 months development time period is subject to approval of the final reform implementation plan, oversight by the Legislature, and can be adjusted. We believe providers will see the opportunities to expand their services and locations.

9. **Where will funding come to expand the capacity of hospitals and other providers to make more beds available?** The Governor has pledged a one-time infusion of $6 million from the Health Care Cash Fund over the biennium (FY04 and FY05 only) for the transition of Regional Center services to the community. Once new capacity is developed and Regional Center patients have been transitioned, funds previously used for Regional Centers will be utilized for ongoing service support, with Medicaid match for some.

   A total of approximately $50 million dollars will be directed toward expanding existing or creating new services in communities:

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10. **How can Hastings and Norfolk continue to be a part of the behavioral health system?** The Road to Recovery offers development opportunities to community providers across the state. The cities of Hastings and Norfolk can continue to participate in the community BH System by expanding their current community-based BH services which will hopefully include employing previous Regional Center state employees into the community-based service agencies. Their community hospitals can also opt to provide acute and secure inpatient services, employing Regional Center employees and can also provide crisis center beds.

11. **How does the new system deal with patients who are difficult to handle and can't manage their illness while living in the community?** The new community-based system will include many levels of services. Some will be very rigid and controlled and others will be supportive only, depending on the needs. Consumers requiring crisis stabilization will access enhanced crisis center services, created by doubling existing crisis center funding. Community hospitals throughout the state will be able to develop acute psychiatric inpatient and secure residential services with the capacity to have locked units and highly trained staff. Non-residential community programs, such as Assertive Community Treatment in Hastings, have a proven capacity to provide services to this population and reduce rehospitalization. Residential rehabilitation services are more restrictive and appropriate for some in transition.

12. **How will funds from Regional Centers be allocated to regions?** The formula for allocations for new and current funds has yet to be determined.

13. **How will Medicaid be leveraged?** The state will be able to receive reimbursement for funding that has been paid for approved services to persons who are Medicaid eligible and who are served in non-institutional community settings (not an IMD/Institute for Mental Disease). The federal funds are reimbursed on a 60% federal, 40% state basis. Therefore, the state will recover 60% of the funds that were spent on Medicaid eligible consumers in the current system.

14. **Why aren't more people entering the Regional Centers Medicaid eligible? (Aren't all people who are poor or disabled Medicaid eligible?) How many patients at Norfolk are eligible for Medicaid?** It has been said by some that no one receiving inpatient care at NRC or HRC is Medicaid eligible. This statement is true – Medicaid will not pay for mental health care a person receives while in a Regional Center, which is classified as an Institute for Mental Disease (IMD). However, it is *also* true that many of these patients are Medicaid eligible just before admission, remain eligible for Medicaid services like acute medical/surgical care while in the Regional Center, and will be eligible again upon discharge.

    We know that approximately 20% of all acute admissions to HRC and NRC were Medicaid covered up to the time of commitment. For those patients at HRC and NRC who have exceeded the average length of stay, 60-80% will be Medicaid eligible upon discharge as a result of disability or age (needing nursing home placement).

MH Commitment Boards do not commit based on financial criteria, but on mental illness or chemical dependency and dangerousness. Mental illness and chemical dependency can impact anyone -- not just those who are poor or disabled. Not all citizens who are poor or disabled are Medicaid eligible, and the Legislature determines Medicaid eligibility criteria.

15. **How long does it take to become Medicaid eligible (after discharge)?** A consumer does not lose Medicaid eligibility when admitted to a Regional Center. Benefits are suspended for the period of hospitalization in the Regional Center and are reactivated upon discharge. The current reactivation processing occurs within five (5) days.

16. **How long does it take to draw SSI after discharge?** SSI is an income from the Social Security Administration. Assuming the consumer is already eligible for Social Security Income or Social Security Disability Income (SSDI), the arrangements to resume disability payments are made prior to the discharge date, and initiated immediately upon discharge. Consumers who are not already eligible for SSI/SSDI must go through the Social Security Administration's disability determination process. The disability determination process is in the Department of Education.

17. **Will peer support be a Medicaid service?** Types of peer support services have been approved by CMS in other states. We are exploring the status of peer support services in those states where there is a history.

18. **Why are resources moving from rural Nebraska and moving them to Omaha?** This is not a rural VS urban issue, it's about serving people closer to where they live. Approximately 70% of patients at Norfolk and 30% at Hastings are from the Omaha area. It is reasonable to create capacity to serve those people closer to home. The $29 million now spent at two Regional Centers will be disbursed across the state, creating services where they are needed, plus the additional funding of $15 million per year in all areas of the state.

19. **Where did the numbers for the Regional Centers come from?** All client information was provided by Regional Center staff to Magellan, which then compiled the data. HHSS mental health systems contractors also reviewed individual patient critieria and discharge recommendations to determine the community-based services needed for the reform planning process. Data regarding discharge needs was obtained for current residents in August, 2003 and again in January, 2004.

20. **Why is Assertive Community Treatment (ACT) not being billed as a Medicaid reimbursable service?** ACT has just recently (December 2003) been approved as a Medicaid reimbursable service by the federal Centers for Medicaid and Medicare Services (CMS). The legal process to promulgate regulations in order to access federal funds is nearing completion and awaiting signature by the Nebraska Attorney General's Office.

21. **What if hospitals do not step up and create capacity for acute/secure patients?** The Road to Recovery offers development opportunities to community providers across the state, including hospitals. The State will support development of new community-based acute inpatient, secure residential and support through reimbursement for the level of care as well as other non-residential support services with current community providers. Or the state may elect to provide these services in smaller state-operated facilities if current community providers choose not to participate.

    In addition, Governor Johanns, Senator Jensen and leaders of HHSS behavioral health administration are keenly aware of the impact of the federal Olmsted court decision that mandates states to move patients to community services, expand community-based treatment and thereby increase alternatives to institutionalization.

22. **Have alternative mental health models been considered?** Yes. The successful alternative to acute and secure care in a Regional Center is the movement of acute and secure services to community-based settings, to ensure consumers are served closer to their home and to improve continuity of care. This model of health care is consistent with national research data supporting moving more mental health services to community settings and restructuring state psychiatric services.

23. **How will we get staff for community-based providers in rural/frontier areas?** The Road to Recovery recognizes that limited human resources in mental health and substance abuse services has long been a problem in serving rural needs in every state. Providers for new or expanded programs can draw upon the expertise of current Regional Center staff. Support and training will also be available across the state through the University of Nebraska and Creighton University medical centers. These two institutions will lend support in numerous ways, including recruiting more students into behavioral health, providing communities with more trained professionals, increasing access to behavioral health expertise through tele-health and tele-education, and producing statewide training programs for clinicians.

24. **What kind of professional credential will the administration and staff of community-based facilities have?** The service standards, including staffing and licensing requirements for cute inpatient and secure residential services, will be the same for new community service providers as they are with the current Regional Center services.

25. **How will behavioral health professionals, particularly psychiatrists, be encouraged to stay in Nebraska, after they have been trained here?** History shows that 50% of residents stay in the service area where they trained. The Behavioral Health Reform will partner with Nebraska's higher institutes of education to address the ongoing shortage of behavioral health professionals and to work with communities to find alternatives. The proposed Academic Center would become a statewide resource and training ground for public-sector behavioral health, integrating clinical services and research, along with helping communities set up community-based programs based on their identified need.

26. **How will human resources, psychiatrists, nurse practitioners, etc., be developed in rural and frontier counties?** The Road to Recovery recognizes that limited human resources in mental health and substance abuse services has long been a problem in serving rural needs in every state. Support and training will be available across the State through the University of Nebraska and Creighton University medical centers. These two institutions have committed to lending support in numerous ways, including recruiting more students into behavioral health, providing communities with more trained professionals, increasing access to behavioral health expertise through tele-health and tele-education, and producing statewide training programs for clinicians.

27. **How many states have closed Regional Centers? How many are adding Regional Centers to replace those that had been closed earlier?**
Information from a 2000 report from the National Association of State Mental Health Program Directors (NASMHPD) showed:
    - In 1999 and 2000, five states have closed seven state psychiatric hospitals (GA, IL, MI (3), NH, and PA). Three states (GA, KS, and NJ) reported plans to close three more state psychiatric hospitals over the next two years. Two states (OH, and TX) had merged two hospitals into a new hospital over the last two years and additional States are planning to merge two or more state hospitals over the next two years.
    - While state hospital closures increased in the 1990s, the closure of state psychiatric hospitals remains largely regional. Most of the states closing state psychiatric hospitals are located in either the Midwest or Northeast (Kansas, Oklahoma, Minnesota, Illinois, Wisconsin, Indiana, Ohio, Pennsylvania, New York, New Jersey, Connnecticut, Rhode Island). Oregon, Alabama, Georgia and South Carolina also join the states that have closed, or are planning to close state psychiatric hospitals.
    - 50% of states (22 of 44 reporting) were reorganizing their state hospital systems.

      1978 to1988 — 9 state psychiatric hospitals closed
      1988 to 1990 — 5 state psychiatric hospitals closed
      1990 to 1999 — 44 state psychiatric hospitals closed
      [Data Source: "State Profile Highlight", NASMHPD Research Institute, Alexandria, VA, August 10, 2000.]

28. **If community services fill up and there is no place to send people who have been committed?** This is one of the current problems that we are addressing through behavioral health reform. With the development of increased capacity, especially in voluntary emergency stabilization/treatment alternatives, the demand for committed treatment capacity will diminish. Funding for EPC capacity is being doubled. New mid-level services can catch people before they escalate, resulting in less need for hospitalization.

29. **What happens to people who need current outpatient services provided by the Regional Centers?** Outpatient services will be contracted for as part of the community-based programming.

30. **Why is the Lincoln Regional Center being kept open if it is an Institute for Mental Disease?** The majority of the capacity of the Lincoln Regional Center will be redirected toward specialty services such as forensics and treatment of sex offenders. Current LRC transitional residential level services will also be moved into the community. It is the state's responsibility to provide psychiatric services for sex offenders, and the state will continue to do so. Within the past year the capacity for this population has been increased.

31. **Will sex offenders be released earlier to community-based services?** No patient will be dismissed until they have reached maximum benefit from the Regional Centers and facilities are available that provide a safe and secure environment for them and the community. Sex offenders at HRC or NRC will be transferred to LRC.

32. **Where will suicidal or violent people who need lockdown facilities be served?** Individuals needing this level of care will continue to be served as long as they meet the criteria for those services. Consumers requiring emergency crisis stabilization can access crisis center services. Governor Johanns' budget included $2.5 million for emergency protective custody capacity, double the current amount of funding. Community hospitals throughout the state that provide acute psychiatric inpatient and secure residential services also have secure settings with the capacity to have locked units, and highly trained staff to work successfully with this population. Omaha will have that capacity as part of the Road to Recovery so those individuals can be treated closer to home.

33. **Will the state or municipalities be responsible for picking the site for new community-based facilities? How many will be needed?** Location of community-based facilities will be determined through the behavioral health reform planning processes. The proposed legislation gives the state stronger oversight of services in the community in order to ensure greater accountability. Specific providers and locations will be determined through a regional planning process that will be conducted over the next few months. The first meeting for this regional planning took place January 23 and included the BH Regional administrators, law enforcement, consumers, advocates and HHSS.

34. **Who decides what zoning or subdivision decisions are required?** Location of community-based services will be a product of joint state and regional planning. Providers of services will remain subject to individual community rules, ordinances and zoning requirements. The state's stronger oversight role will help ensure greater accountability.

35. **What support will consumers in the community who move to independent living be given?** Supportive services are dependent upon a comprehensive evaluation of need and may include medication management/assistance, budgeting, how to use public transportation and other activities of daily living.

36. **Consumers who are committed to Regional Centers can have their medications paid for by HHSS (LB95). If Regional Centers close how will they get their medications.** The parameters of LB95 will be revised to accommodate the changes needed in the system because of BH Reform. The BH system will continue to assist committed consumers with the costs of psychotropic medications.

37. **What will be done to provide more housing in communities so consumers can stay in the community?** The Governor has proposed earmarking $3.5 million from the documentary stamp tax revenues currently designated for affordable housing to develop or provide housing specifically for persons with chronic mental illness beginning in FY 05. A range of housing options are currently being developed, ranging from Residential Rehabilitation facilities to providing rental assistance. The type of housing available will be consistent with consumer preference. Non-institutional community housing will be a priority.

    HHSS is collaboratively working with Long Term Care, Assisted Living, the Department of Economic Development and local interested parties to improve housing and develop more alternatives for the citizens of Nebraska. For example, HHS is exploring rental assistance vouchers for consumers who had been served in Regional Centers. In addition, we hope to leverage some additional funds for housing through HUD and NIFA.

38. **Can the state guarantee no one will be sent to a homeless shelter?** This currently happens, but very rarely. The discharge of any consumer to a homeless shelter, whether from a Regional Center or other behavioral health provider, including private providers, is not considered good practice, nor is it consistent with effective discharge planning. It is the intent of all caregivers to make the most appropriate discharge placements whenever possible. The BH Reform will emphasize appropriate discharge planning in outcome measures in assessing and managing the performance of the system. Serving consumers closer to their homes should also decrease the likelihood of such a discharge

39. **How many patients were sent to a homeless shelter from the Regional Centers?** In FY03, 3.2% (38) of the consumers from HRC and NRC were discharged to homeless shelters. The three Regional Centers average 1,100 admissions annually. [Data source: Regional Center AIMS database.]

40. **How can the state ensure that consumers are treated in the most appropriate manner?** BH service providers, including Regional Centers, are accredited nationally, have facility and professional licensure, and are held to specific practice and ethical standards of active consumer participation in treatment planning and discharge. Numerous auditing processes are in place to review treatment practice and outcomes.

41. **What will be done to provide employment for consumers?** HHS is developing collaborations with other systems including Department of Education, Vocational Rehabilitation that can provide employment opportunities for persons disabled by severe and persistent mental illness. The current rehabilitation and support services in the BH system include training to assist persons with severe and persistent mental illness to attain the skills to take advantage of those opportunities as well as support consumers who are employed.